TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Marcus P. Hayes, D.C.

Respondent Name
VIA Metropolitan Transit

MFDR Tracking Number
M4-17-0079-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
September 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The IC has received this claim on two separate occasions. The first submission was received via regular mail and the second via fax. The IC has not responded to either submission."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because Dr. Arredondo's certification of May 24, 2016 was not the first evaluation of maximum medical improvement and impairment rating, the Claimant was not entitled to a subsequent evaluation by Dr. Hayes. As such, the evaluation of June 8, 2016 does not represent reasonable or necessary medical treatment for the compensable injury, nor was it otherwise authorized under the Texas Labor Code or Division Rules. Therefore, Respondent asserts that Requestor is not entitled to reimbursement for the services rendered on June 8, 2016."

Response Submitted by: Adami, Shuffield, Scheihing & Burns

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2016	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008 until September 1, 2016.

3. The submitted documentation does not include explanations of benefits for the services in question.

Issues

1. Did VIA Metropolitan Transit introduce new issues not provided to Dr. Hayes prior to his request for medical fee dispute resolution (MFDR)?
2. What is the maximum allowable reimbursement (MAR) for the services in question?
3. Is Dr. Hayes entitled to reimbursement of the services in question?

Findings

1. Marcus Hayes, D.C. is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating as a referral doctor selected by the treating doctor. Documentation submitted to the division supports that Dr. Hayes did submit a medical bill on or about August 1, 2016.

   In its position statement, VIA Metropolitan Transit asserted:

   > Because Dr. Arredondo's certification of May 24, 2016 was not the first evaluation of maximum medical improvement and impairment rating, the Claimant was not entitled to a subsequent evaluation by Dr. Hayes. As such, the evaluation of June 8, 2016 does not represent reasonable or necessary medical treatment for the compensable injury, nor was it otherwise authorized under the Texas Labor Code or Division Rules.

   Texas Administrative Code §33.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   Evidence submitted to the division does not support that the denial reasons asserted by VIA Metropolitan Transit in its position statement were presented to Dr. Hayes prior to his request for MFDR. Therefore, the division concludes that these are new issues and will not be considered for this dispute.

2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. Hayes performed an evaluation of Maximum Medical Improvement. Therefore, the MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation… (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used." The submitted documentation supports that Dr. Hayes performed an evaluation to determine the impairment rating of the lumbar spine using the DRE method found in the AMA Guides 4th edition. Therefore, the MAR for this examination is $150.00.

3. The total MAR for the disputed services is $500.00. VIA Metropolitan Transit paid $0.00. A reimbursement of $500.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 9, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.